BEP 1
7/2017
Bureau of Eligibility Policy

State of Utah
Department of Health
Division of Medicaid & Health Financing

UPP Lost Check & Replacement Form

Information Provided by the Payee

I, _____ confirm that I am unable to locate the UPP check for the month(s) of _____ and request that the State of Utah Department of Health, stop payment on the original check and issue a replacement check.

Please mail the replacement check to the following address:
Name: (First, MI, Last):_____
Mailing Address: _____
City, State, Zip Code: _____
Telephone #: (___) _____
Case Number or Date of Birth: _____

_____ _____
Signature of Payee ***Date***

Once the Department of Health receives the completed form, your request will be processed and a replacement check will be issued. If you locate the original check after you have returned this form, do not deposit or cash the check. Contact the UPP Administration office at (801) 538-6192.
Please allow 10 business days for processing and mailing of the replacement check.

Return completed form to:

Department of Health
Bureau of Eligibility Policy
UPP

Form may be submitted by:

Email: UPP@utah.gov
Fax: (801) 538-6952
Mail: PO Box 143107
SLC, UT 84114-3107

For Department of Health Use Only		
Payee _____		Benefit Month: _____
Original Check #:_____	Check Amount: _____	Check Date: _____
Duplicate Check #: _____	Date Mailed/Released: _____	Approved by: _____